COMMONWEALTH OF KENTUCKY
PERSONNEL CABINET
DEPARTMENT OF EMPLOYEE INSURANCE

2010 KEHP UPDATE FORM
(FOR BOARD OF EDUCATION USE ONLY)
TO BE USED FOR PINK- SLIPPED EMPLOYEES

To be completed by the Insurance Coordinator.

GENERAL INFORMATION (REQUIRED)

SOCIAL SECURITY NUMBER	**COMPANY NUMBER**
NAME	**COMPANY NAME**

CONTRACT

Did the employee fulfill his/her contract for the school year? Yes ☐ or No ☐
Enter employee term date: _____

PREMIUMS

Did the employee pay his/her premiums for the summer months?
Yes ☐ or No ☐
Please mark the month that you received the full premium amount.
JUNE ☐ JULY ☐ AUGUST ☐
If paid a half month premium please give the coverage end date.
Last date through which Premiums paid:_____

TERMINATION/CONTRIBUTIONS FSA

Please enter the health insurance termination date: _____

Did the employee pay his/her contribution for their FSA? Yes ☐ or No ☐

Please mark the month that you received the full contribution.
JUNE ☐ JULY ☐ AUGUST☐
Please enter the FSA termination date: _____

I acknowledge and understand that DEI will comply with the HIPAA Rules and that disclosure of information will be done under the rules of such Federal law. I further authorize DEI to use such information and to disclose such information to third party administrators, vendors, consultants, governmental authorities with jurisdiction and other necessary parties when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities.

EMPLOYEE SIGNATURE	DATE	COORDINATOR SIGNATURE	DATE

Insurance Coordinator: Mail this form to Dept. of Employee Insurance, 501 High St., 2nd Floor, Frankfort, KY 40601

Revised 02/24/2010